[MEDICAID RECONCILIATION PROVISIONS, AS REPORTED BY THE COMMITTEE ON COMMERCE ON JUNE 12, 1997]

Subtitle E—Medicaid

SEC. 3400. TABLE OF CONTENTS OF SUBTITLE; REFERENCES.

(a) TABLE OF CONTENTS OF SUBTITLE.—The table of contents of this subtitle is as follows:

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this subtitle an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference is considered to be made to that section or other provision of the Social Security Act.

CHAPTER 1—STATE FLEXIBILITY

Subchapter A—Use of Managed Care

SEC. 3401. STATE OPTIONS TO PROVIDE BENEFITS THROUGH MANAGED CARE ENTITIES.

(a) IN GENERAL.—Section 1915(a) (42 U.S.C. 1396n(a)) is amended—

(1) by striking ''or'' at the end of paragraph (1),

(2) by striking the period at the end of paragraph (2) and inserting ''; or'', and

(3) by adding at the end the following new paragraph:

''(3) requires individuals, other than special needs children (as defined in subsection (i)), eligible for medical assistance for items or services under the State plan to enroll with an entity that provides or arranges for services for enrollees under a contract pursuant to section 1903(m), or with a primary care case manager (as defined in section 1905(t)(2)) (or restricts the number of provider agreements with those entities under the State plan, consistent with quality of care), if—

''(A) the State permits an individual to choose the manager or managed care entity from among the managed care organizations and primary care case providers who meet the requirements of this title;

''(B)(i) individuals are permitted to choose between at least 2 of those entities, or 2 of the managers, or an entity and a manager, each of which has sufficient capacity to provide services to enrollees; or

''(ii) with respect to a rural area—

''(I) individuals who are required to enroll with a single entity are afforded the option to obtain covered services by an alternative provider; and

''(II) an individual who is offered no alternative to a single entity or manager is given a choice between at least two providers within the entity or through the manager;

''(C) no individual who is an Indian (as defined in section 4 of the Indian Health Care Improvement Act of 1976) is required to enroll in any entity that is not one of the following (and only if such entity is participating under the plan): the Indian Health Service, an Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, coop-

erative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.), or an urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.);

"(D) the State restricts those individuals from changing their enrollment without cause for periods no longer than six months (and permits enrollees to change enrollment for cause at any time);

"(E) the restrictions do not apply to providers of family planning services (as defined in section 1905(a)(4)(C)) and are not conditions for payment of medicare cost sharing pursuant to section 1905(p)(3); and

"(F) prior to establishing an enrollment requirement under this paragraph, the State agency provides for public notice and comment pursuant to requirements established by the Secretary.".

(b) SPECIAL NEEDS CHILDREN DEFINED.—Section 1915 (42 U.S.C. 1396n) is amended by adding at the end the following:

"(i) For purposes of subsection (a)(3), the term 'special needs child' means an individual under 19 years of age who—

"(1) is eligible for supplemental security income under title XVI,

"(2) is described in section 501(a)(1)(D),

"(3) is described in section 1902(e)(3), or

"(4) is in foster care or otherwise in an out-of-home placement.".

(c) CONFORMING AMENDMENT TO RISK-BASED ARRANGEMENTS.—Section 1903(m)(2) (42 U.S.C. 1396b(m)(2)) is amended—

(1) in paragraph (A)(vi)—

(A) by striking "(I) except as provided under subparagraph (F),"; and

(B) by striking all that follows ''to terminate such enrollment'' and inserting ''in accordance with the provisions of subparagraph (F);''; and

(2) in subparagraph (F)—

(A) by striking ''In the case of—'' and all that follows through ''a State plan'' and inserting ''A State plan'', and

(B) by striking ''(A)(vi)(I)'' and inserting ''(A)(vi)''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act.

SEC. 3402. ELIMINATION OF 75:25 RESTRICTION ON RISK CONTRACTS.

(a) 75 PERCENT LIMIT ON MEDICARE AND MEDICAID ENROLLMENT.—

(1) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended by striking clause (ii).

(2) CONFORMING AMENDMENTS.—Section 1903(m)(2) (42 U.S.C. 1396b(m)(2)) is amended—

(A) by striking subparagraphs (C), (D), and (E); and

(B) in subparagraph (G), by striking ''clauses (i) and (ii)'' and inserting ''clause (i)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on the date of the enactment of this Act.

SEC. 3403. PRIMARY CARE CASE MANAGEMENT SERVICES AS STATE OPTION WITHOUT NEED FOR WAIVER.

(a) OPTIONAL COVERAGE AS PART OF MEDICAL ASSISTANCE.—Section 1905(a) (42 U.S.C. 1396d(a)) is amended—

(1) by striking ''and'' at the end of paragraph (24);

(2) by redesignating paragraph (25) as paragraph (26) and by striking the period at the end of such paragraph and inserting a comma; and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) primary care case management services (as defined in subsection (t)); and''.

(b) PRIMARY CARE CASE MANAGEMENT SERVICES DEFINED.—Section 1905 (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

''(t)(1) The term 'primary care case management services' means case-management related services (including coordination and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

''(2)(A) The term 'primary care case manager' means, with respect to a primary care case management contract, a provider described in subparagraph (B).

''(B) A provider described in this subparagraph is a provider that provides primary care case management services under contract and is—

''(i) a physician, a physician group practice, or an entity employing or having other arrangements with physicians; or

''(ii) at State option—

''(I) a nurse practitioner (as described in section 1905(a)(21));

''(II) a certified nurse-midwife (as defined in section 1861(gg)); or

''(III) a physician assistant (as defined in section 1861(aa)(5)).

''(3) The term 'primary care case management contract' means a contract with a State agency under which a primary care case manager undertakes to locate, coordinate and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the primary care case manager, and which provides for—

''(A) reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

''(B) restriction of enrollment to individuals residing sufficiently near a service delivery site of the entity to be

able to reach that site within a reasonable time using available and affordable modes of transportation;

"(C) employment of, or contracts or other arrangements with, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

"(D) a prohibition on discrimination on the basis of health status or requirements for health services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this title; and

"(E) a right for an enrollee to terminate enrollment without cause during the first month of each enrollment period, which period shall not exceed six months in duration, and to terminate enrollment at any time for cause.

"(4) For purposes of this subsection, the term 'primary care' includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.".

(c) CONFORMING AMENDMENTS.—Section 1902 (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(10)(C)(iv), by striking "(24)" and inserting "(25)", and

(2) in subsection (j), by striking "(25)" and inserting "(26)".

(d) EFFECTIVE DATE.—The amendments made by this section apply to primary care case management services furnished on or after October 1, 1997.

SEC. 3404. CHANGE IN THRESHOLD AMOUNT FOR CONTRACTS REQUIRING SECRETARY'S PRIOR APPROVAL.

(a) IN GENERAL.—Section 1903(m)(2)(A)(iii) (42 U.S.C. 1396b(m)(2)(A)(iii)) is amended by striking "$100,000" and inserting "$1,000,000 for 1998 and, for a subsequent year, the

amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contracts entered into or renewed on or after the date of the enactment of this Act.

SEC. 3405. DETERMINATION OF HOSPITAL STAY.

(a) IN GENERAL.—Title XIX, as amended by section 3431(a), is amended—

(1) by redesignating section 1933 as section 1934, and

(2) by inserting after section 1932 the following new section:

''DETERMINATION OF HOSPITAL STAY

''SEC. 1933. (a) IN GENERAL.—A Medicaid health plan shall cover the length of an inpatient hospital stay under this title as determined by the attending physician (or other attending health care provider to the extent permitted under State law) in consultation with the patient to be medically appropriate.

''(b) CONSTRUCTION.—Nothing in this title shall be construed—

''(1) as requiring the provision of inpatient coverage if the attending physician (or other attending health care provider to the extent permitted under State law) and patient determine that a shorter period of hospital stay is medically appropriate, or

''(2) as affecting the application of deductibles and coinsurance.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to discharges occurring on or after 6 months after the date of the enactment of this Act.

Subchapter B—Payment Methodology

SEC. 3411. FLEXIBILITY IN PAYMENT METHODS FOR HOSPITAL, NURSING FACILITY, AND ICF/MR SERVICES; FLEXIBILITY FOR HOME HEALTH.

(a) REPEAL OF BOREN REQUIREMENTS.—Section 1902(a)(13) (42 U.S.C. 1396a(a)) is amended—

(1) by amending subparagraphs (A) and (B) to read as follows:

''(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

''(i) proposed rates are published, and providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates;

''(ii) final rates are published, together with justifications, and

''(iii) in the case of hospitals, take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low income patients with special needs;

''(B) that the State shall provide assurances satisfactory to the Secretary that the average level of payments under the plan for nursing facility services (as determined on an aggregate per resident-day basis) and the level of payments under the plan for inpatient hospital services (as determined on an aggregate hospital payment basis) furnished during the 18-month period beginning October 1, 1997, is not less than the average level of payments that would be made under the plan during such 18-month period for such respective services (determined on such basis) based on rates or payment basis in effect as of May 1, 1997;''; and

(2) by striking subparagraph (C).

(b) REPEAL OF REQUIREMENTS RELATING TO HOME HEALTH SERVICES.—Such section is further amended—

(1) by adding ''and'' at the end of subparagraph (D),

(2) by striking ''and'' at the end of subparagraph (E), and

(3) by striking subparagraph (F).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for items and services furnished on or after the date of the enactment of this Act.

SEC. 3412. PAYMENT FOR CENTER AND CLINIC SERVICES.

(a) PHASE-OUT OF PAYMENT BASED ON REASONABLE COSTS.—Section 1902(a)(13)(E) (42 U.S.C. 1396a(a)(13)(E)) is amended by inserting ''(or 95 percent for services furnished during fiscal year 2000, 90 percent for service furnished during fiscal year 2001, and 85 percent for services furnished during fiscal year 2002)'' after ''100 percent''.

(b) TRANSITIONAL SUPPLEMENTAL PAYMENT FOR SERVICES FURNISHED UNDER CERTAIN MANAGED CARE CONTRACTS.—

(1) IN GENERAL.—Section 1902(a)(13)(E) is further amended—

(A) by inserting ''(i)'' after ''(E)'', and

(B) by inserting before the semicolon at the end the following: ''and (ii) in carrying out clause (i) in the case of services furnished by a federally qualified health center or a rural health clinic pursuant to a contract between the center and a health maintenance organization under section 1903(m), for payment by the State of a supplemental payment equal to the amount (if any) by which the amount determined under clause (i) exceeds the amount of the payments provided under such contract''.

(2) CONFORMING AMENDMENT TO MANAGED CARE CONTRACT REQUIREMENT.—Clause (ix) of section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended to read as follows:

''(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services with a federally qualified health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were fur-

nished by a provider which is not a federally qualified health center or a rural health clinic;''.

(3) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1997.

(c) END OF TRANSITIONAL PAYMENT RULES.—Effective for services furnished on or after October 1, 2002—

(1) subparagraph (E) of section 1902(a)(13) (42 U.S.C. 1396a(a)(13)) is repealed, and

(2) clause (ix) of section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is repealed.

(d) FLEXIBILITY IN COVERAGE OF NON-FREESTANDING LOOK-ALIKES.—

(1) IN GENERAL.—Section 1905(l)(2)(B)(iii) (42 U.S.C. 1396d(l)(2)(B)(iii)) is amended by inserting ''and is not other than an entity that is owned, controlled, or operated by another provider'' after ''such a grant''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to service furnished on and after the date of the enactment of this Act.

(e) GAO REPORT.—By not later than February 1, 2001, the Comptroller General shall submit to Congress a report on the impact of the amendments made by this section on access to health care for medicaid beneficiaries and the uninsured served at health centers and rural health clinics and the ability of health centers and rural health clinics to become integrated in a managed care system.

SEC. 3413. TREATMENT OF STATE TAXES IMPOSED ON CERTAIN HOSPITALS THAT PROVIDE FREE CARE.

(a) EXCEPTION FROM TAX DOES NOT DISQUALIFY AS BROAD-BASED TAX.—Section 1903(w)(3) (42 U.S.C. 1396b(w)(3)) is amended—

(1) in subparagraph (B), by striking ''and (E)'' and inserting ''(E), and (F)'', and

(2) by adding at the end the following:

"(F) In no case shall a tax not qualify as a broad-based health care related tax under this paragraph because it does not apply to a hospital that is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986 and that does not accept payment under the State plan under this title or under title XVIII.".

(b) REDUCTION IN FEDERAL FINANCIAL PARTICIPATION IN CASE OF IMPOSITION OF TAX.—Section 1903(b) (42 U.S.C. 1396b(b)) is amended by adding at the end the following:

"(4) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State shall be decreased in a quarter by the amount of any health care related taxes (described in section 1902(w)(3)(A)) that are imposed on a hospital described in subsection (w)(3)(F) in that quarter.".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to taxes imposed before, on, or after the date of the enactment of this Act and the amendment made by subsection (b) shall apply to taxes imposed on or after such date.

Subchapter C—Eligibility

SEC. 3421. STATE OPTION OF CONTINUOUS ELIGIBILITY FOR 12 MONTHS; CLARIFICATION OF STATE OPTION TO COVER CHILDREN.

(a) CONTINUOUS ELIGIBILITY OPTION.—Section 1902(e) (42 U.S.C. 1396a(e)) is amended by adding at the end the following new paragraph:

"(12) At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this title under subsection (a)(10)(A) shall remain eligible for those benefits until the earlier of—

"(A) the end of a period (not to exceed 12 months) following the determination; or

"(B) the time that the individual exceeds that age.".

(b) CLARIFICATION OF STATE OPTION TO COVER ALL CHILDREN UNDER 19 YEARS OF AGE.—Section 1902(l)(1)(D) (42 U.S.C. 1396a(l)(1)(D)) is amended by inserting ''(or, at the option of a State, after any earlier date)'' after ''children born after September 30, 1983''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to medical assistance for items and services furnished on or after October 1, 1997.

SEC. 3422. PAYMENT OF HOME-HEALTH-RELATED MEDICARE PART B PREMIUM AMOUNT FOR CERTAIN LOW-INCOME INDIVIDUALS.

(a) ELIGIBILITY.—Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended—

(1) by striking ''and'' at the end of clause (ii), and

(2) by inserting after clause (iii) the following:

''(iv) subject to section 1905(p)(4), for making medical assistance available for the portion of medicare cost sharing described in section 1905(p)(3)(A)(ii), that is attributable to the application under section 1839(a)(5) of section 1833(d)(2) for individuals who would be described in clause (iii) but for the fact that their income exceeds 120 percent, but is less than 175 percent, of the official poverty line (referred to in section 1905(p)(2)) for a family of the size involved;''.

(b) 100 PERCENT FEDERAL PAYMENT.—The third sentence of section 1905(b) (42 U.S.C. 1396d(b)) is amended by inserting ''and with respect to amounts expended for medical assistance described in section 1902(a)(10)(E)(iv) for individuals described in such section'' before the period at the end..

SEC. 3423. PENALTY FOR FRAUDULENT ELIGIBILITY.

Section 1128B(a) (42 U.S.C. 1320a–7b(a)), as amended by section 217 of the Health Insurance Portability and Accountability Act of 1996, is amended—

(1) by amending paragraph (6) to read as follows:

''(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eli-

gible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),''; and

(2) in clause (ii) of the matter following such paragraph, by striking ''failure, or conversion by any other person'' and inserting ''failure, conversion, or provision of counsel or assistance by any other person''.

SEC. 3424. TREATMENT OF CERTAIN SETTLEMENT PAYMENTS.

Notwithstanding any other provision of law, the payments made from any fund established pursuant to the settlement in the case of In re Factor VIII or IX Concentrate Blood Products Litigation, MDL–986, no. 93–C7452 (N.D. Ill.) shall not be considered income or resources in determining eligibility for, or the amount of benefits under, a State plan of medical assistance approved under title XIX of the Social Security Act.

Subchapter D—Programs of All-inclusive Care for the Elderly (PACE)

SEC. 3431. ESTABLISHMENT OF PACE PROGRAM AS MEDICAID STATE OPTION.

(a) IN GENERAL.—Title XIX is amended—

(1) in section 1905(a) (42 U.S.C. 1396d(a)), as amended by section 3403(a)—

(A) by striking ''and'' at the end of paragraph (25);

(B) by redesignating paragraph (26) as paragraph (27); and

(C) by inserting after paragraph (25) the following new paragraph:

''(26) services furnished under a PACE program under section 1932 to PACE program eligible individuals enrolled under the program under such section; and'';

(2) by redesignating section 1932 as section 1933; and

(3) by inserting after section 1931 the following new section:

"PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

"SEC. 1932. (a) OPTION.—

"(1) IN GENERAL.—A State may elect to provide medical assistance under this section with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. Such individuals need not be eligible for benefits under part A, or enrolled under part B, of title XVIII to be eligible to enroll under this section. In the case of an individual enrolled with a PACE program pursuant to such an election—

"(A) the individual shall receive benefits under the plan solely through such program, and

"(B) the PACE provider shall receive payment in accordance with the PACE program agreement for provision of such benefits.

A State may limit through its PACE program agreement the number of individuals who may be enrolled in a PACE program under the State plan.

"(2) PACE PROGRAM DEFINED.—For purposes of this section and section 1894, the term 'PACE program' means a program of all-inclusive care for the elderly that meets the following requirements:

"(A) OPERATION.—The entity operating the program is a PACE provider (as defined in paragraph (3)).

"(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

"(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program

agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

"(3) PACE PROVIDER DEFINED.—

"(A) IN GENERAL.—For purposes of this section, the term 'PACE provider' means an entity that—

"(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986, and

"(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

"(B) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—Clause (i) of subparagraph (A) shall not apply—

"(i) to entities subject to a demonstration project waiver under subsection (h); and

"(ii) after the date the report under section 4014(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C) or (D) of paragraph (2) of such section are true.

"(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term 'PACE program agreement' means, with respect to a PACE provider, an agreement, consistent with this section, section 1894 (if applicable), and regulations promulgated to carry out such sections, between the PACE provider, the Secretary, and a State administering agency for the operation of a PACE program by the provider under such sections.

"(5) PACE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'PACE pro-

gram eligible individual' means, with respect to a PACE program, an individual who—

"(A) is 55 years of age or older;

"(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

"(C) resides in the service area of the PACE program; and

"(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

"(6) PACE PROTOCOL.—For purposes of this section, the term 'PACE protocol' means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995.

"(7) PACE DEMONSTRATION WAIVER PROGRAM DEFINED.—For purposes of this section, the term 'PACE demonstration waiver program' means a demonstration program under either of the following sections (as in effect before the date of their repeal):

"(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

"(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

"(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term 'State administering agency' means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under this title in the State) responsible for administering PACE program agreements under this section and section 1894 in the State.

"(9) TRIAL PERIOD DEFINED.—

"(A) IN GENERAL.—For purposes of this section, the term 'trial period' means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

"(B) TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.—Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

"(10) REGULATIONS.—For purposes of this section, the term 'regulations' refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1894.

"(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

"(1) IN GENERAL.—Under a PACE program agreement, a PACE provider shall—

"(A) provide to PACE program eligible individuals, regardless of source of payment and directly or under contracts with other entities, at a minimum—

"(i) all items and services covered under title XVIII (for individuals enrolled under section 1894) and all items and services covered under this title, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under such title or this title, respectively; and

"(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

"(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

"(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

"(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

"(2) QUALITY ASSURANCE; PATIENT SAFEGUARDS.—The PACE program agreement shall require the PACE provider to have in effect at a minimum—

"(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations, and

"(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this title and Federal and State law designed for the protection of patients.

"(c) ELIGIBILITY DETERMINATIONS.—

"(1) IN GENERAL.—The determination of whether an individual is a PACE program eligible individual—

"(A) shall be made under and in accordance with the PACE program agreement, and

"(B) who is entitled to medical assistance under this title, shall be made (or who is not so entitled, may be made) by the State administering agency.

"(2) CONDITION.—An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such deter-

mination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.

"(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least once a year.

"(B) EXCEPTION.—The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases where the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the advanced age, severity of the advanced age, severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

"(4) CONTINUATION OF ELIGIBILITY.—An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6–month period.

"(5) ENROLLMENT; DISENROLLMENT.—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

"(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.—

"(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the State shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section.

"(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be an amount, specified under the PACE agreement, which is less than the amount that would otherwise have been made under the State plan if the individuals were not so enrolled and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. The payment under this section shall be in addition to any payment made under section 1894 for individuals who are enrolled in a PACE program under such section.

"(e) PACE PROGRAM AGREEMENT.—

"(1) REQUIREMENT.—

"(A) IN GENERAL.—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1894, and regulations.

"(B) NUMERICAL LIMITATION.—

"(i) IN GENERAL.—The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

"(I) 40 as of the date of the enactment of this section, or

"(II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

"(ii) TREATMENT OF CERTAIN PRIVATE, FOR-PROFIT PROVIDERS.—The numerical limitation in clause (i) shall not apply to a PACE provider that—

"(I) is operating under a demonstration project waiver under subsection (h), or

"(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

"(2) SERVICE AREA AND ELIGIBILITY.—

"(A) IN GENERAL.—A PACE program agreement for a PACE program—

"(i) shall designate the service area of the program;

"(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

"(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

"(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

"(v) shall have such additional terms and conditions as the parties may agree to consistent with this section and regulations.

"(B) SERVICE AREA OVERLAP.—In designating a service area under a PACE program agreement under

subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

"(3) DATA COLLECTION.—

"(A) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

"(i) collect data,

"(ii) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records, and

"(iii) make to the Secretary and the State administering agency reports that the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program under this title and title XVIII.

"(B) REQUIREMENTS DURING TRIAL PERIOD.—During the first three years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

"(4) OVERSIGHT.—

"(A) ANNUAL, CLOSE OVERSIGHT DURING TRIAL PERIOD.—During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure com-

pliance with the requirements of this section and regulations. Such a review shall include—

"(i) an on-site visit to the program site;

"(ii) comprehensive assessment of a provider's fiscal soundness;

"(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

"(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

"(v) any other elements the Secretary or State agency considers necessary or appropriate.

"(B) CONTINUING OVERSIGHT.—After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

"(C) DISCLOSURE.—The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

"(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

"(A) IN GENERAL.—Under regulations—

"(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause, and

"(ii) a PACE provider may terminate such an agreement after appropriate notice to the Secretary, the State agency, and enrollees.

"(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination

of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

"(i) the Secretary or State administering agency determines that—

"(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

"(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1894; and

"(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, and continue implementation of a plan to correct the deficiencies.

"(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

"(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

"(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

"(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

"(ii) Withhold some or all further payments under the PACE program agreement under this

section or section 1894 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

"(iii) Terminate such agreement.

"(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1857(f)(2) (or, for periods before January 1, 1999, section 1876(i)(6)(B)) or 1903(m)(6)(B) in the case of violations by the provider of the type described in section 1857(f)(1) (or 1876(i)(6)(A) for such periods) or 1903(m)(6)(A), respectively (in relation to agreements, enrollees, and requirements under section 1894 or this section, respectively).

"(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1857(g) (or for periods before January 1, 1999, section 1876(i)(9)) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a MedicarePlus organization under part C (or for such periods an eligible organization under section 1876).

"(8) TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

"(f) REGULATIONS.—

"(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1894.

"(2) USE OF PACE PROTOCOL.—

"(A) IN GENERAL.—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

"(B) FLEXIBILITY.—The Secretary (in close consultation with State administering agencies) may modify or waive such provisions of the PACE protocol in order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use non-staff physicians accordingly to State licensing law requirements) under this section and section 1932 where such flexibility is not inconsistent with and would not impair the essential elements, objectives, and requirements of the this section, including—

"(i) the focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility;

"(ii) the delivery of comprehensive, integrated acute and long-term care services;

"(iii) the interdisciplinary team approach to care management and service delivery;

"(iv) capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals; and

"(v) the assumption by the provider over time of full financial risk.

"(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

"(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may

apply with respect to PACE programs, providers, and agreements such requirements of part C of title XVIII (or, for periods before January 1, 1999, section 1876) and section 1903(m) relating to protection of beneficiaries and program integrity as would apply to MedicarePlus organizations under such part C (or for such periods eligible organizations under risk-sharing contracts under section 1876) and to health maintenance organizations under prepaid capitation agreements under section 1903(m).

"(B) CONSIDERATIONS.—In issuing such regulations, the Secretary shall—

"(i) take into account the differences between populations served and benefits provided under this section and under part C of title XVIII (or, for periods before January 1, 1999, section 1876) and section 1903(m);

"(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

"(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XVIII.

"(g) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) shall not apply:

"(1) Section 1902(a)(1), relating to any requirement that PACE programs or PACE program services be provided in all areas of a State.

"(2) Section 1902(a)(10), insofar as such section relates to comparability of services among different population groups.

"(3) Sections 1902(a)(23) and 1915(b)(4), relating to freedom of choice of providers under a PACE program.

"(4) Section 1903(m)(2)(A), insofar as it restricts a PACE provider from receiving prepaid capitation payments.

"(h) DEMONSTRATION PROJECT FOR FOR-PROFIT ENTITIES.—

"(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

"(2) SIMILAR TERMS AND CONDITIONS.—

"(A) IN GENERAL.—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

"(B) NUMERICAL LIMITATION.—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

"(i) POST-ELIGIBILITY TREATMENT OF INCOME.—A State may provide for post-eligibility treatment of income for individuals enrolled in PACE programs under this section in the same manner as a State treats post-eligibility income for individuals receiving services under a waiver under section 1915(c).

"(j) MISCELLANEOUS PROVISIONS.—

"(1) CONSTRUCTION.—Nothing in this section or section 1894 shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, of title XVIII or eligible for medical assistance under this title.".

(b) CONFORMING AMENDMENTS.—

(1) Section 1902 (42 U.S.C. 1396a), as amended by section 3403(c), is amended—

(A) in subsection (a)(10)(C)(iv), by striking ''(25)'' and inserting ''(26)'', and

(B) in subsection (j), by striking ''(26)'' and inserting ''(27)''.

(2) Section 1924(a)(5) (42 U.S.C. 1396r–5(a)(5)) is amended—

(A) in the heading, by striking ''FROM ORGANIZATIONS RECEIVING CERTAIN WAIVERS'' and inserting ''UNDER PACE PROGRAMS'', and

(B) by striking ''from any organization'' and all that follows and inserting ''under a PACE demonstration waiver program (as defined in subsection (a)(7) of section 1932) or under a PACE program under section 1894.''.

(3) Section 1903(f)(4)(C) (42 U.S.C. 1396b(f)(4)(C)) is amended by inserting ''or who is a PACE program eligible individual enrolled in a PACE program under section 1932,'' after ''section 1902(a)(10)(A),''.

SEC. 3432. COVERAGE OF PACE UNDER THE MEDICARE PROGRAM.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1894 the following new section:

''PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

''SEC. 1894. (a) RECEIPT OF BENEFITS THROUGH ENROLLMENT IN PACE PROGRAM; DEFINITIONS FOR PACE PROGRAM RELATED TERMS.—

''(1) BENEFITS THROUGH ENROLLMENT IN A PACE PROGRAM.—In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual with respect to a PACE program offered by a PACE provider under a PACE program agreement—

''(A) the individual may enroll in the program under this section; and

''(B) so long as the individual is so enrolled and in accordance with regulations—

"(i) the individual shall receive benefits under this title solely through such program, and

"(ii) the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.

"(2) APPLICATION OF DEFINITIONS.—The definitions of terms under section 1932(a) shall apply under this section in the same manner as they apply under section 1932.

"(b) APPLICATION OF MEDICAID TERMS AND CONDITIONS.—Except as provided in this section, the terms and conditions for the operation and participation of PACE program eligible individuals in PACE programs offered by PACE providers under PACE program agreements under section 1932 shall apply for purposes of this section.

"(c) PAYMENT.—

"(1) ADJUSTMENT IN PAYMENT AMOUNTS.—In the case of individuals enrolled in a PACE program under this section, the amount of payment under this section shall not be the amount calculated under section 1932(d)(2), but shall be an amount, specified under the PACE agreement, based upon payment rates established for purposes of payment under section 1854 (or, for periods before January 1, 1999, for purposes of risk-sharing contracts under section 1876) and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this title for a comparable population not enrolled under a PACE program.

"(2) FORM.—The Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under this section in the same manner and from the same sources as payments are made to a MedicarePlus organization under section 1854 (or, for periods beginning before January 1, 1999, to

an eligible organization under a risk-sharing contract under section 1876). Such payments shall be subject to adjustment in the manner described in section 1854(a)(2) or section 1876(a)(1)(E), as the case may be.

''(d) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) are waived and shall not apply:

''(1) Section 1812, insofar as it limits coverage of institutional services.

''(2) Sections 1813, 1814, 1833, and 1886, insofar as such sections relate to rules for payment for benefits.

''(3) Sections 1814(a)(2)(B), 1814(a)(2)(C), and 1835(a)(2)(A), insofar as they limit coverage of extended care services or home health services.

''(4) Section 1861(i), insofar as it imposes a 3-day prior hospitalization requirement for coverage of extended care services.

''(5) Sections 1862(a)(1) and 1862(a)(9), insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.''.

SEC. 3433. EFFECTIVE DATE; TRANSITION.

(a) TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE DATE.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subchapter in a timely manner. Such regulations shall be designed so that entities may establish and operate PACE programs under sections 1894 and 1932 for periods beginning not later than 1 year after the date of the enactment of this Act.

(b) EXPANSION AND TRANSITION FOR PACE DEMONSTRATION PROJECT WAIVERS.—

(1) EXPANSION IN CURRENT NUMBER AND EXTENSION OF DEMONSTRATION PROJECTS.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(g) of the Omnibus Budget Reconciliation Act of 1987, is amended—

(A) in paragraph (1), by inserting before the period at the end the following: ", except that the Secretary shall grant waivers of such requirements to up to the applicable numerical limitation specified in section 1932(e)(1)(B) of the Social Security Act"; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ", including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk"; and

(ii) in subparagraph (C), by adding at the end the following: "In granting further extensions, an organization shall not be required to provide for reporting of information which is only required because of the demonstration nature of the project.".

(2) ELIMINATION OF REPLICATION REQUIREMENT.—Subparagraph (B) of paragraph (2) of such section shall not apply to waivers granted under such section after the date of the enactment of this Act.

(3) TIMELY CONSIDERATION OF APPLICATIONS.—In considering an application for waivers under such section before the effective date of repeals under subsection (c), subject to the numerical limitation under the amendment made by paragraph (1), the application shall be deemed approved unless the Secretary of Health and Human Services, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(c) PRIORITY AND SPECIAL CONSIDERATION IN APPLICATION.—During the 3-year period beginning on the date of the enactment of this Act:

(1) PROVIDER STATUS.—The Secretary of Health and Human Services shall give priority, in processing applications of entities to qualify as PACE programs under section 1894 or 1932 of the Social Security Act—

(A) first, to entities that are operating a PACE demonstration waiver program (as defined in section 1932(a)(7) of such Act), and

(B) then entities that have applied to operate such a program as of May 1, 1997.

(2) NEW WAIVERS.—The Secretary shall give priority, in the awarding of additional waivers under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986—

(A) to any entities that have applied for such waivers under such section as of May 1, 1997; and

(B) to any entity that, as of May 1, 1997, has formally contracted with a State to provide services for which payment is made on a capitated basis with an understanding that the entity was seeking to become a PACE provider.

(3) SPECIAL CONSIDERATION.—The Secretary shall give special consideration, in the processing of applications described in paragraph (1) and the awarding of waivers described in paragraph (2), to an entity which as of May 1, 1997 through formal activities (such as entering into contracts for feasibility studies) has indicated a specific intent to become a PACE provider.

(d) REPEAL OF CURRENT PACE DEMONSTRATION PROJECT WAIVER AUTHORITY.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), the following provisions of law are repealed:

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21).

(B) Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(C) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(2) DELAY IN APPLICATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the repeals made by paragraph (1) shall not apply to waivers granted before the initial effective date of regulations described in subsection (a).

(B) APPLICATION TO APPROVED WAIVERS.—Such repeals shall apply to waivers granted before such date only after allowing such organizations a transition period (of up to 24 months) in order to permit sufficient time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this subchapter.

(3) STATE OPTION.—A State may elect to maintain the PACE program which (as of the date of the enactment of this Act) were operating under the authority described in paragraph (1) without electing to use the authority under section 1932 of the Public Health Service Act.

SEC. 3434. STUDY AND REPORTS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in section 1932(a)(8) of the Social Security Act) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this subchapter.

(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under section 1932(h) of the Social Security Act with the costs, quality, and access to services of other PACE providers.

(b) REPORT.—

(1) IN GENERAL.—Not later than 4 years after the date of the enactment of this Act, the Secretary shall provide for a report to Congress on the impact of such amend-

ments on quality and cost of services. The Secretary shall include in such report such recommendations for changes in the operation of such amendments as the Secretary deems appropriate.

(2) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—The report shall include specific findings on whether any of the following findings is true:

(A) The number of covered lives enrolled with entities operating under demonstration project waivers under section 1932(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

(D) The application of such section has resulted in an increase in expenditures under the medicare or medicaid programs above the expenditures that would have been made if such section did not apply.

(c) INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS.—The Medicare Payment Advisory Commission shall include in its annual report under section 1805(b)(1)(B) of the Social Security Act recommendations on the methodology and level of payments made to PACE providers under section 1894(d) of such Act and on the treatment of private, for-profit entities as PACE providers.

Subchapter E—Benefits

SEC. 3441. ELIMINATION OF REQUIREMENT TO PAY FOR PRIVATE INSURANCE.

(a) REPEAL OF STATE PLAN PROVISION.—Section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is amended—

(1) by striking subparagraph (G); and

(2) by redesignating subparagraphs (H) and (I) as subparagraphs (G) and (H), respectively.

(b) MAKING PROVISION OPTIONAL.—Section 1906 (42 U.S.C. 1396e) is amended—

(1) in subsection (a)—

(A) by striking ''For purposes of section 1902(a)(25)(G) and subject to subsection (d), each'' and inserting ''Each'',

(B) in paragraph (1), by striking ''shall'' and inserting ''may'', and

(C) in paragraph (2), by striking ''shall'' and inserting ''may''; and

(2) by striking subsection (d).

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 3442. PERMITTING SAME COPAYMENTS IN HEALTH MAINTENANCE ORGANIZATIONS AS IN FEE-FOR-SERVICE.

(a) IN GENERAL.—Section 1916(a)(2)(D) (42 U.S.C. 1396o(a)(2)(D)) is amended by inserting ''(at the option of the State)'' after ''section 1905(a)(4)(C), or''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost sharing with respect to deductions, cost sharing and similar charges imposed for items and services furnished on or after the date of the enactment of this Act.

SEC. 3443. PHYSICIAN QUALIFICATION REQUIREMENTS.

(a) IN GENERAL.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended by striking paragraph (12)

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after the date of the enactment of this Act.

SEC. 3444. ELIMINATION OF REQUIREMENT OF PRIOR INSTITUTIONALIZATION WITH RESPECT TO HABILITATION SERVICES FURNISHED UNDER A WAIVER FOR HOME OR COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—Section 1915(c)(5) (42 U.S.C. 1396n(c)(5)) is amended, in the matter preceding subparagraph (A), by striking '', with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) apply to services furnished on or after October 1, 1997.

SEC. 3445. BENEFITS FOR SERVICES OF PHYSICIAN ASSISTANTS.

(a) IN GENERAL.—Section 1905(a) (42 U.S.C. 1396d(a)), as amended by sections 3403(a) and 3431(a), is amended—

(1) by redesignating paragraphs (22) through (27) as paragraphs (23) through (28), and

(2) by inserting after paragraph (21) the following new paragraph:

''(22) services furnished by an physician assistant (as defined in section 1861(aa)(5)) which the assistant is legally authorized to perform under State law and with the supervision of a physician;''.

(b) CONFORMING AMENDMENTS.—Section 1902 (42 U.S.C. 1396a), as amended by sections 3403(c) and 3431(b)(1), is amended—

(1) in subsection (a)(10)(C)(iv), by striking ''(26)'' and inserting ''(27)'', and

(2) in subsection (j), by striking ''(27)'' and inserting ''(28)''.

SEC. 3446. STUDY AND REPORT ON ACTUARIAL VALUE OF EPSDT BENEFIT.

(a) STUDY.—The Secretary of Health and Human Services shall provide for a study on the actuarial value of the provision of early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r) of the Social Secu-

rity Act (42 U.S.C. 1396d(r))) under the medicaid program under title XIX of such Act. Such study shall include an examination of the portion of such value that is attributable to paragraph (5) of such section and to the second sentence of such section.

(b) REPORT.—By not later than 18 months after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the results of the study under subsection (a).

Subchapter F—Administration

SEC. 3451. ELIMINATION OF DUPLICATIVE INSPECTION OF CARE REQUIREMENTS FOR ICFS/MR AND MENTAL HOSPITALS.

(a) MENTAL HOSPITALS.—Section 1902(a)(26) (42 U.S.C. 1396a(a)(26)) is amended—

(1) by striking ''provide—

''(A) with respect to each patient'' and inserting ''provide, with respect to each patient''; and

(2) by striking subparagraphs (B) and (C).

(b) ICFS/MR.—Section 1902(a)(31) (42 U.S.C. 1396a(a)(31)) is amended—

(1) by striking ''provide—

''(A) with respect to each patient'' and inserting ''provide, with respect to each patient''; and

(2) by striking subparagraphs (B) and (C).

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act.

SEC. 3452. ALTERNATIVE SANCTIONS FOR NONCOMPLIANT ICFS/MR.

(a) IN GENERAL.—Section 1902(i)(1)(B) (42 U.S.C. 1396a(i)(1)(B)) is amended by striking ''provide'' and inserting ''establish alternative remedies if the State demonstrates to the Secretary's satisfaction that the alternative remedies are effective in deterring noncompliance and correcting deficiencies, and may provide''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) takes effect on the date of the enactment of this Act.

SEC. 3453. MODIFICATION OF MMIS REQUIREMENTS.

(a) IN GENERAL.—Section 1903(r) (42 U.S.C. 1396b(r)) is amended—

(1) by striking all that precedes paragraph (5) and inserting the following:

''(r)(1) In order to receive payments under subsection (a) for use of automated data systems in administration of the State plan under this title, a State must have in operation mechanized claims processing and information retrieval systems that meet the requirements of this subsection and that the Secretary has found—

''(A) is adequate to provide efficient, economical, and effective administration of such State plan;

''(B) is compatible with the claims processing and information retrieval systems used in the administration of title XVIII, and for this purpose—

''(i) has a uniform identification coding system for providers, other payees, and beneficiaries under this title or title XVIII;

''(ii) provides liaison between States and carriers and intermediaries with agreements under title XVIII to facilitate timely exchange of appropriate data; and

''(iii) provides for exchange of data between the States and the Secretary with respect to persons sanctioned under this title or title XVIII;

''(C) is capable of providing accurate and timely data;

''(D) is complying with the applicable provisions of part C of title XI;

''(E) is designed to receive provider claims in standard formats to the extent specified by the Secretary; and

''(F) effective for claims filed on or after January 1, 1999, provides for electronic transmission of claims data in the format specified by the Secretary and consistent with

the Medicaid Statistical Information System (MSIS) (including detailed individual enrollee encounter data and other information that the Secretary may find necessary).''.

(2) in paragraph (5)—

(A) by striking subparagraph (B);

(B) by striking all that precedes clause (i) and inserting the following:

''(2) In order to meet the requirements of this paragraph, mechanized claims processing and information retrieval systems must meet the following requirements:'';

(C) in clause (iii), by striking ''under paragraph (6)''; and

(D) by redesignating clauses (i) through (iii) as paragraphs (A) through (C); and

(3) by striking paragraphs (6), (7), and (8).

(b) CONFORMING AMENDMENTS.—Section 1902(a)(25)(A)(ii) (42 U.S.C. 1396a(a)(25)(A)(ii)) is amended by striking all that follows ''shall'' and inserting the following: ''be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval system under section 1903(r);''.

(c) EFFECTIVE DATE.—Except as otherwise specifically provided, the amendments made by this section shall take effect on January 1, 1998.

SEC. 3454. FACILITATING IMPOSITION OF STATE ALTERNATIVE REMEDIES ON NONCOMPLIANT NURSING FACILITIES.

(a) IN GENERAL.—Section 1919(h)(3)(D) (42 U.S.C. 1396r(h)(3)(D)) is amended—

(1) by inserting ''and'' at the end of clause (i);

(2) by striking '', and'' at the end of clause (ii) and inserting a period; and

(3) by striking clause (iii).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on the date of the enactment of this Act.

SEC. 3455. MEDICALLY ACCEPTED INDICATION.

Section 1927(g)(1)(B)(i) (42 U.S.C. 1396r–8(g)(1)(B)(i)) is amended—

(1) by striking ''and'' at the end of subclause (II),

(2) by redesignating subclause (III) as subclause (IV), and

(3) by inserting after subclause (II) the following:

''(III) the DRUGDEX Information System; and''.

SEC. 3456. CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS.

(a) IN GENERAL.—Section 1115 (42 U.S.C. 1315) is amended by adding at the end the following new subsection:

''(e)(1) The provisions of this subsection shall apply to the extension of State-wide comprehensive demonstration project (in this subsection referred to as 'waiver project') for which a waiver of compliance with requirements of title XIX is granted under subsection (a).

''(2) Not earlier than 1 year before the date the waiver under subsection (a) with respect to a waiver project would otherwise expire, the chief executive officer of the State which is operating the project may submit to the Secretary a written request for an extension, of up to 3 years, of the project.

''(3) If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted.

''(4) If such a request is granted, the deadline for submittal of a final report under the waiver project is deemed to have been extended until the date that is 1 year after the date the waivers under subsection (a) with respect to the project would otherwise have expired.

''(5) The Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final report.

''(6) Subject to paragraphs (4) and (7), the extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions

relating to quality and access of services, budget neutrality, data and reporting requirements, and special population protections) that applied to the project before its extension under this subsection.

''(7) If an original condition of approval of a waiver project was that Federal expenditures under the project not exceed the Federal expenditures that would otherwise have been made, the Secretary shall take such steps as may be necessary to assure that, in the extension of the project under this subsection, such condition continues to be met. In applying the previous sentence, the Secretary shall take into account the Secretary's best estimate of rates of change in expenditures at the time of the extension.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to demonstration projects initially approved before, on, or after the date of the enactment of this Act.

SEC. 3457. AUTHORIZING ADMINISTRATIVE STREAMLINING AND PRIVATIZING MODIFICATIONS UNDER THE MEDICAID PROGRAM.

Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following:

''(aa)(1) Notwithstanding any other provision of law, no provision of law shall be construed as preventing any State from allowing determinations of eligibility to receive medical assistance under this title to be made by an entity that is not a State or local government, or by an individual who is not an employee of a State or local government, which meets such qualifications as the State determines. For purposes of any Federal law, such determinations shall be considered to be made by the State and by a State agency.

''(2) Nothing in this subsection shall be construed as affecting—

''(A) the conditions for eligibility for benefits (including any conditions relating to income or resources); and

''(B) the rights to challenge determinations regarding eligibility or rights to benefits; and

''(C) determinations regarding quality control or error rates.''.

SEC. 3458. EXTENSION OF MORATORIUM.

Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993, is amended by striking ''December 31, 1995'' and inserting ''December 31, 2002''.

CHAPTER 2—QUALITY ASSURANCE

SEC. 3461. REQUIREMENTS TO ENSURE QUALITY OF AND ACCESS TO CARE UNDER MANAGED CARE PLANS.

(a) STATE PLAN REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (62), by striking ''; and'' at the end and inserting a semicolon;

(2) by striking the period at the end of paragraph (63) and inserting ''; and''; and

(3) by inserting after paragraph (63) the following new paragraph:

''(64) provide, with respect to all contracts described in section 1903(m)(2)(A) with an organization or provider, that—

''(A) the State agency develops and implements a quality assessment and improvement strategy, consistent with standards that the Secretary shall establish, in consultation with the States, and monitor and that do not preempt the application of stricter State standards, which includes—

''(i) standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and, where applicable, specialized services capacity, including pediatric specialized services for special needs children (as defined in section 1915(i)); and

''(ii) procedures for monitoring and evaluating the quality and appropriateness of care and serv-

ices to beneficiaries that reflect the full spectrum of populations enrolled under the contract and that include—

"(I) requirements for provision of quality assurance data to the State using the data and information set that the Secretary shall specify with respect to entities contracting under section 1876 or alternative data requirements approved by the Secretary;

"(II) regular and periodic examination of the scope and content of the quality improvement strategy; and

"(III) other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards); and

"(B) that adequate provision is made, consistent with standards that the Secretary shall specify and monitor, with respect to financial reporting under the contracts.".

(b) DEEMED COMPLIANCE.—Section 1903(m) (42 U.S.C. 1396b(m)) is amended by adding at the end the following:

"(7) DEEMED COMPLIANCE.—

"(A) MEDICARE ORGANIZATIONS.—At the option of a State, the requirements of the previous provisions of this subsection shall not apply with respect to a health maintenance organization if the organization is an eligible organization with a contract in effect under section 1876 or a MedicarePlus organization with a contract in effect under C of title XVIII.

"(B) PRIVATE ACCREDITATION.—

"(i) IN GENERAL.—At the option of a State, such requirements shall not apply with respect to a health maintenance organization if—

"(I) the organization is accredited by an organization meeting the requirements described in subparagraph (C); and

''(II) the standards and process under which the organization is accredited meet such requirements as are established under clause (ii), without regard to whether or not the time requirement of such clause is satisfied.

''(ii) STANDARDS AND PROCESS.—Not later than 180 days after the date of the enactment of this paragraph, the Secretary shall specify requirements for the standards and process under which a health maintenance organization is accredited by an organization meeting the requirements of subparagraph (C).

''(C) ACCREDITING ORGANIZATION.—An accrediting organization meets the requirements of this subparagraph if the organization—

''(i) is a private, nonprofit organization;

''(ii) exists for the primary purpose of accrediting managed care organizations or health care providers; and

''(iii) is independent of health care providers or associations of health care providers.''.

(c) APPLICATION TO MANAGED CARE ENTITIES.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

(1) by striking ''and'' at the end of clause (x),

(2) by striking the period at the end of clause (xi) and inserting ''; and'', and

(3) by adding at the end the following new clause:

''(xii) such contract provides for—

''(I) submitting to the State agency such information as may be necessary to monitor the care delivered to members,

''(II) maintenance of an internal quality assurance program consistent with section 1902(a)(64)(A), and meeting standards that the Secretary shall establish in regulations; and

''(III) providing effective procedures for hearing and resolving grievances between the entity and mem-

bers enrolled with the organization under this subsection.''.

(d) APPLICATION TO PRIMARY CARE CASE MANAGEMENT CONTRACTS.—Section 1905(t)(3), as added by section 3403(b), is amended—

(1) by striking ''and'' at the end of subparagraph (D),

(2) by striking the period at the end of subparagraph (E) and inserting ''; and'', and

(3) by adding at the end the following new subparagraph:

''(F) if payment is made to the organization on a prepaid capitated or other risk basis, compliance with the requirements of section 1903(m)(2)(A)(xii) in the same manner such requirements apply to a health maintenance organization under section 1903(m)(2)(A).''.

(e) EFFECTIVE DATE.—The amendments made by this section apply to agreements between a State agency and an organization entered into or renewed on or after January 1, 1999.

SEC. 3462. SOLVENCY STANDARDS FOR CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.

(a) IN GENERAL.—Section 1903(m)(1) (42 U.S.C. 1396b(m)(1)) is amended—

(1) in subparagraph (A)(ii), by inserting '', meets the requirements of subparagraph (C)(i) (if applicable),'' after ''provision is satisfactory to the State'', and

(2) by adding at the end the following:

''(C)(i) Subject to clause (ii), a provision meets the requirements of this subparagraph for an organization if the organization meets solvency standards established by the State for private health maintenance organizations or is licensed or certified by the State as a risk-bearing entity.

''(ii) Clause (i) shall not apply to an organization if—

''(I) the organization is not responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and physicians' services;

''(II) the organization is a public entity;

"(III) the solvency of the organization is guaranteed by the State; or

"(IV) the organization is (or is controlled by) one or more federally-qualified health centers and meets solvency standards established by the State for such an organization.

For purposes of subclause (IV), the term 'control' means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent."

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to contracts entered into or renewed on or after October 1, 1998.

(c) TRANSITION.—In the case of a health maintenance organization that as of the date of the enactment of this Act has entered into a contract with a State for the provision of medical assistance under title XIX under which the organization assumes full financial risk and is receiving capitation payments, the amendment made by subsection (a) shall not apply to such organization until 3 years after the date of the enactment of this Act.

SEC. 3463. APPLICATION OF PRUDENT LAYPERSON STANDARD FOR EMERGENCY MEDICAL CONDITION AND PROHIBITION OF GAG RULE RESTRICTIONS.

Section 1903(m) (42 U.S.C. 1396b(m)) is amended by adding at the end the following:

"(8)(A)(i) Each contract with a health maintenance organization under this subsection shall require the organization—

"(I) to provide coverage for emergency services (as defined in subparagraph (B)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization, and

"(II) to comply with guidelines established under section 1852(d)(2) (respecting coordination of post-stabiliza-

tion care) in the same manner as such guidelines apply to MedicarePlus plans offered under part C of title XVIII.

"(B) In subparagraph (A)(i)(I), the term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

"(i) are furnished by a provider that is qualified to furnish such services under this title, and

"(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (C)).

"(C) In subparagraph (B)(ii), the term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

"(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

"(ii) serious impairment to bodily functions, or

"(iii) serious dysfunction of any bodily organ or part.

"(9)(A) Subject to subparagraphs (B) and (C), under a contract under this subsection a health maintenance organization (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

"(B) Subparagraph (A) shall not be construed as requiring a health maintenance organization to provide, reimburse for, or provide coverage of a counseling or referral service if the organization—

"(i) objects to the provision of such service on moral or religious grounds; and

''(ii) in the manner and through the written instrumentalities such organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

''(C) Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

''(D) For purposes of this paragraph, the term 'health care professional' means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the contract under this subsection for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.''.

SEC. 3464. ADDITIONAL FRAUD AND ABUSE PROTECTIONS IN MANAGED CARE.

(a) PROTECTION AGAINST MARKETING ABUSES.—Section 1903(m) (42 U.S.C. 1396b(m)), as amended by section 3463, is amended—

(1) in paragraph (2)(A)(viii), by inserting ''and compliance with the requirements of paragraphs (10) and (11)'' after ''of this subsection'', and

(2) by adding at the end the following:

''(10)(A)(i) A health maintenance organization with respect to activities under this subsection may not distribute directly or through any agent or independent contractor marketing materials within any State—

''(I) without the prior approval of the State; and

''(II) that contain false or materially misleading information.

''(ii) In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

''(iii) The State may not enter into or renew a contract with a health maintenance organization for the provision of services to individuals enrolled under the State plan under this title if the State determines that the entity distributed directly or through any agent or independent contractor marketing materials in violation of clause (i)(II).

''(B) A health maintenance organization shall distribute marketing materials to the entire service area of such organization.

''(C) A health maintenance organization, or any agency of such organization, may not seek to influence an individual's enrollment with the organization in conjunction with the sale of any other insurance.

''(D) Each health maintenance organization shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the organization under this title, the individual is provided accurate oral and written and sufficient information to make an informed decision whether or not to enroll.

''(E) Each health maintenance organization shall not, directly or indirectly, conduct door-to-door, telephonic, or other 'cold call' marketing of enrollment under this title.''.

(b) PROHIBITING AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES.—Section 1903(m) (42 U.S.C. 1396b(m)), as amended by section 3463 and subsection (a), is further amended by adding at the end the following:

''(11)(A) A health maintenance organization may not knowingly—

''(i) have a person described in subparagraph (C) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the organization equity; or

"(ii) have an employment, consulting, or other agreement with a person described in such subparagraph for the provision of items and services that are significant and material to the organization's obligations under its contract with the State.

"(B) If a State finds that a health maintenance organization is not in compliance with clause (i) or (ii) of subparagraph (A), the State—

"(i) shall notify the Secretary of such noncompliance;

"(ii) may continue an existing agreement with the organization unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) directs otherwise; and

"(iii) may not renew or otherwise extend the duration of an existing agreement with the organization unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) provides to the State and to the Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

"(C) A person is described in this subparagraph if such person—

"(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal acquisition regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order 12549; or

"(ii) is an affiliate (within the meaning of the Federal acquisition regulation) of a person described in clause (i).".

(c) APPLICATION OF STATE CONFLICT-OF-INTEREST SAFEGUARDS.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)), as amended by section 3461(c), is amended—

(1) by striking "and" at the end of clause (xi),

(2) by striking the period at the end of clause (xii) and inserting "; and", and

(3) by inserting after clause (xi) the following:

"(xiii) the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations and to any default enrollment process that are at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423), against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.".

(d) LIMITATION ON AVAILABILITY OF FFP FOR USE OF ENROLLMENT BROKERS.—Section 1903(b) (42 U.S.C. 1396b(b)), as amended by section 3413(b), is amended by adding at the end the following:

"(5) Amounts expended by a State for the use an enrollment broker in marketing health maintenance organizations and other managed care entities to eligible individuals under this title shall be considered, for purposes of subsection (a)(7), to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

"(A) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this title) that provide coverage of services in the same State in which the broker is conducting enrollment activities.

"(B) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this title or title XVIII or debarred by any Federal agency, or subject to a civil money penalty under this Act.".

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1998.

SEC. 3465. GRIEVANCES UNDER MANAGED CARE PLANS.

Section 1903(m) (42 U.S.C. 1396b(m)) is amended—

(1) in paragraph (2)(A), as amended by sections 3461(c) and 3464(c),—

(A) by striking ''and'' at the end of clause (xii),

(B) by striking the period at the end of clause (xiii) and inserting ''; and'', and

(C) by inserting after clause (xiii) the following new clause:

''(xiv) such contract provides for compliance of the organization with the grievance and appeals requirements described in paragraph (3).''; and

(2) by inserting after paragraph (2) the following new paragraph:

''(3)(A) An eligible organization must provide a meaningful and expedited procedure, which includes notice and hearing requirements, for resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this subsection. Under the procedure any member enrolled with the organization may at any time file orally or in writing a complaint to resolve grievances between the member and the organization before a board of appeals established under subparagraph (C).

''(B)(i) The organization must provide, in a timely manner, such an enrollee a notice of any denial of services in-network or denial of payment for out-of-network care or notice of termination or reduction of services.

''(ii) Such notice shall include the following:

''(I) A clear statement of the reason for the denial.

''(II) An explanation of the complaint process under subparagraph (C) which is available to the enrollee upon request.

''(III) An explanation of all other appeal rights available to all enrollees.

''(IV) A description of how to obtain supporting evidence for this hearing, including the patient's medical records from the organization, as well as supporting affidavits from the attending health care providers.

''(C)(i) Each eligible organization shall establish a board of appeals to hear and make determinations on complaints by enrollees under this subsection concerning denials of coverage or payment for services (whether in-network or out-of-network) and the medical necessity and appropriateness of covered items and services.

''(ii) A board of appeals of an eligible organization shall consist of—

''(I) representatives of the organization, including physicians, nonphysicians, administrators, and enrollees;

''(II) consumers who are not enrollees; and

''(III) providers with expertise in the field of medicine which necessitates treatment.

''(iii) A board of appeals shall hear and resolve complaints within 30 days after the date the complaint is filed with the board.

''(D) Nothing in this paragraph may be construed to replace or supersede any appeals mechanism otherwise provided for an individual entitled to benefits under this title.''.

SEC. 3466. STANDARDS RELATING TO ACCESS TO OBSTETRICAL AND GYNECOLOGICAL SERVICES UNDER MANAGED CARE PLANS.

(a) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)), as amended by sections 3461(c), 3464(c), and 3465(1), is amended—

(1) by striking ''and'' at the end of clause (xiii),

(2) by striking the period at the end of clause (xiv) and inserting ''; and'', and

(3) by inserting after clause (xiv) the following:

''(xv) the organization complies with the requirements of paragraph (12).''.

(b) REQUIREMENTS.—Section 1903(m) (42 U.S.C. 1396b(m)), as amended by sections 3463, 3464(a), and 3464(b), is amended by adding at the end the following new paragraph:

''(12)(A) If a health maintenance organization, under a contract under this subsection, requires or provides for an enrollee to designate a participating primary care provider—

''(i) the organization shall permit a female enrollee to designate an obstetrician-gynecologist who has agreed to be designated as such, as the enrollee's primary care provider; and

''(ii) if such an enrollee has not designated such a provider as a primary care provider, the organization—

''(I) may not require prior authorization by the enrollee's primary care provider or otherwise for coverage of obstetric and gynecologic care provided by a participating obstetrician-gynecologist, or a participating health care professional practicing in collaboration with the obstetrician-gynecologist and in accordance with State law, to the extent such care is otherwise covered, and

''(II) shall treat the ordering of other gynecologic care by such a participating physician as the prior authorization of the primary care provider with respect to such care under the contract.

''(B) Nothing in subparagraph (A)(ii)(II) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecologic care so ordered.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into, renewed, or extended on or after January 1, 1998.

CHAPTER 3—FEDERAL PAYMENTS

SEC. 3471. REFORMING DISPROPORTIONATE SHARE PAYMENTS UNDER STATE MEDICAID PROGRAMS.

(a) DIRECT PAYMENT BY STATE.—Subsection (a)(1) of section 1923 (42 U.S.C. 1396r–4) is amended—

(1) by striking ''and'' at the end of subparagraph (A),

(2) by striking the period at the end of subparagraph (B) and inserting '', and'', and

(3) by adding at the end the following new subparagraph:

"(C) provides that payment adjustments under the plan under this section for services furnished by a hospital on or after October 1, 1997, for individuals entitled to benefits under the plan, and enrolled with an entity described in section 1903(m), under a primary care case management system (described in section 1905(t)), or other managed care plan—

"(i) are made directly to the hospital by the State, and

"(ii) are not used as part of, and are disregarded in determining the amount of, prepaid capitation paid under the State plan with respect to those services.".

(b) ADJUSTMENT TO STATE DSH ALLOCATIONS.—

(1) IN GENERAL.—Subsection (f) of such section is amended—

(A) in paragraph (2)(A), by inserting "and paragraph (5)" after "subparagraph (B)", and

(B) by adding at the end the following new paragraph:

"(5) ADJUSTMENTS IN DSH ALLOTMENTS.—

"(A) ALLOTMENT FROZEN FOR STATES WITH VERY LOW DSH EXPENDITURES.—In the case of a State for which its State 1995 DSH spending did not exceed 1 percent of the total amount expenditures made under the State plan under this title for medical assistance during fiscal year 1995 (as reported by the State no later than January 1, 1997, on HCFA Form 64), the DSH allotment for each of fiscal years 1998 through 2002 is equal to its State 1995 DSH spending.

"(B) FULL REDUCTION FOR HIGH DSH STATES.—In the case of a State which was classified under this subsection as a high DSH State for fiscal year 1997, the DSH allotment for each of fiscal years 1998

through 2002 is equal to the State 1995 DSH spending reduced by the full reduction percentage (described in subparagraph (D)) for the fiscal year involved.

"(C) HALF-REDUCTION FOR OTHER STATES.—In the case of a State not described in subparagraph (A) or (B), the DSH allotment for each of fiscal years 1998 through 2002 is equal to the State 1995 DSH spending reduced by ½ of the full reduction percentage for the fiscal year involved.

"(D) FULL REDUCTION PERCENTAGE.—For purposes of this paragraph, the 'full reduction percentage' for—

"(i) fiscal year 1998 is 2 percent,

"(ii) fiscal year 1999 is 5 percent,

"(iii) fiscal year 2000 is 20 percent,

"(iv) fiscal year 2001 is 30 percent, and

"(v) fiscal year 2002 is 40 percent.

"(E) DEFINITIONS.— In this paragraph:

"(i) STATE.—The term 'State' means the 50 States and the District of Columbia.

"(ii) STATE 1995 DSH SPENDING.—The term 'State 1995 DSH spending' means, with respect to a State, the total amount of payment adjustments made under subsection (c) under the State plan during fiscal year 1995 as reported by the State no later than January 1, 1997, on HCFA Form 64.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to fiscal years beginning with fiscal year 1998.

(c) TRANSITION RULE.—Effective October 1, 1997, section 1923(g)(2)(A) of the Social Security Act (42 U.S.C. 1396r–4(g)(2)(A)) shall be applied to the State of California as though—

(1) "or that begins on or after October 1, 1997, and before October 1, 1999" were inserted in such section after "January 1, 1995"; and

(2) ''(or 175 percent in the case of a State fiscal year that begins on or after October 1, 1997, and before October 1, 1999)'' were inserted in such section after ''200 percent''.

SEC. 3472. ADDITIONAL FUNDING FOR STATE EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—There are available for allotments under this section for each of the 5 fiscal years (beginning with fiscal year 1998) $20,000,000 for payments to certain States under this section.

(b) STATE ALLOTMENT AMOUNT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall compute an allotment for each fiscal year beginning with fiscal year 1998 and ending with fiscal year 2002 for each of the 12 States with the highest number of undocumented aliens. The amount of such allotment for each such State for a fiscal year shall bear the same ratio to the total amount available for allotments under subsection (a) for the fiscal year as the ratio of the number of undocumented aliens in the State in the fiscal year bears to the total of such numbers for all such States for such fiscal year. The amount of allotment to a State provided under this paragraph for a fiscal year that is not paid out under subsection (c) shall be available for payment during the subsequent fiscal year.

(2) DETERMINATION.—For purposes of paragraph (1), the number of undocumented aliens in a State under this section shall be determined based on estimates of the resident illegal alien population residing in each State prepared by the Statistics Division of the Immigration and Naturalization Service as of October 1992 (or as of such later date if such date is at least 1 year before the beginning of the fiscal year involved),

(c) USE OF FUNDS.—From the allotments made under subsection (b), the Secretary shall pay to each State amounts the State demonstrates were paid by the State (or by a political

subdivision of the State) for emergency health services furnished to undocumented aliens.

(d) STATE DEFINED.—For purposes of this section, the term ''State'' includes the District of Columbia.

(e) STATE ENTITLEMENT.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under subsection (c).